CMS Disclaimer–User Agreement

Transparency Public Use Files

The Centers for Medicare & Medicaid Services (CMS) is pleased to make the Transparency Public Use File (Transparency PUF) containing data related to Qualified Health Plans (QHPs), including Stand-alone Dental Plans (SADPs), sold on a Health Insurance Exchange[SM] [1] available to the public as a free download. The Transparency PUF is intended to support studies requiring the use and analysis of plan data.

This Disclaimer–User Agreement details the sources and nature of the data, including potential limitations, and specifies the responsibility of the data user regarding the processing and understanding of the data files. In addition to this Disclaimer–User Agreement, users should also read the Transparency PUF General File Documentation and Data Dictionary.

Data accuracy: The 2017-2026 Transparency PUF public data is derived from data from Plan Year 2015-2024, respectively. It reflects information for plans sold through the Federally-facilitated Exchanges (FFEs), including FFEs where States perform plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs). It is important to note that the 2026 Transparency PUF is the latest available and subject to change. CMS anticipates publishing a Transparency PUF on an annual basis, and in some cases CMS may publish an updated Transparency PUF to ensure the most accurate data are available to the public. CMS does not guarantee 100% accuracy of all records and all fields. CMS publishes data limitations for their statistical data sources on the Internet. Users must familiarize themselves with the data limitations documents and accept the quality of the data they receive. Please read the Transparency PUF General File Documentation and Data Dictionary before conducting any analyses with the data.

Data integrity: It is the responsibility of each user to identify the information needed to satisfy the user's needs. Any alteration of the original data, including conversion to other media or other data formats, is the responsibility of the user. Data that have been manipulated or reprocessed by the user is the responsibility of the user. The user may not present or otherwise reference data that have been altered in any way as CMS data. CMS has no responsibility for the data after it has been converted, processed or otherwise altered. CMS has no responsibility for assisting users with converting the data to another format. The Data Dictionary for the PUF lists variables and their definitions.

The Center for Medicare & Medicaid Services requests that users cite CMS as the data source in any publications or research based upon these data. Please use the following citation format:

Centers for Medicare & Medicaid Services. (2026). 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025 or 2026 Transparency Public Use File [Data file and data dictionary]. Retrieved from https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html

Additional terms and conditions: User acknowledges that CMS reserves the right to amend or modify this Disclaimer-User Agreement, and that future use of the Transparency PUF may be subject to revised or additional terms and conditions.

[1] Health Insurance Exchange[SM] and Exchange[SM] are service marks of the U.S. Department of Health & Human Services.

Disclaimers to be placed in the PUF:

Enrollment disclaimer: Data on enrollment reflect a monthly average, assessed at the plan level, for calendar year January 1 to December 31 for the respective plan years. The data provided is for plans sold by an issuer on the FFEs, including FFEs where States perform plan management functions, and SBE-FPs only. This information is not a complete description of issuer or plan enrollment. Enrollment is not necessarily indicative of issuer strength or plan quality. Enrollment may change daily due to a variety of circumstances.

Disenrollment disclaimer: Data on disenrollment reflects a monthly average, assessed at the plan level, for calendar year January 1 to December 31 for the respective plan years. The data provided is for plans sold by an issuer on the FFEs, including FFEs where States perform plan management functions, and SBE-FPs only. The data includes disenrollment for all reasons, including but not limited to failure to pay premiums and a consumer's voluntary decision to disenroll from a plan. This information is not a complete description of an issuer or plan. Disenrollment is not necessarily indicative of issuer strength or plan quality.

Claims denial data: Data on claims denials reflects issuer and plan level data, for services rendered during the calendar year January 1 to December 31. The data provided is an aggregate number for plans sold by an issuer on the FFEs, including FFEs where States perform plan management functions, and SBE-FPs only. The issuer level data includes claims denials for all reasons. Issuers could deny claims for various reasons, and this information simply provides a raw number. The plan level data includes claims denials broken down into various categories. Claims denials are not necessarily indicative of issuer strength or plan quality.

Claims appeals data: Data on claims appeals reflects issuer level data, for services rendered during the calendar year January 1 to December 31. The data provided is an aggregate number for plans sold by an issuer on the FFEs, including FFEs where States perform plan management functions, and SBE-FPs only. The number of appeals filed is not necessarily indicative of issuer strength or plan quality.

Pharmacy claims received and denied data: Data on pharmacy claims received and denied reflects plan level data, for services rendered during the calendar year January 1 to December 31. The data provided is an aggregate number for plans sold by an issuer on the FFEs, including FFEs where States perform plan management functions, and SBE-FPs only. At their discretion, issuers determined whether to place pharmacy claims denials in the "Lack of Medical Necessity, Excluding Behavioral Health" category or the "Lack of Medical Necessity, Including Behavioral Health" category when providing a claim count, based on factors including but not limited to the drug prescribed and the diagnosis. This information simply provides a raw number and is not a complete description of an issuer or plan. Claims received and number of claims denied are not necessarily indicative of issuer strength or plan quality.

Data organization in the PUF: Transparency in Coverage data is separated into three sheets within the PUF based on market and plan type as follows:

- Transparency 2026 – Ind QHP (Individual Marketplace Medical QHPs)
- Transparency 2026 – Ind SADP (Individual Marketplace Stand Alone Dental Plans)
- Transparency 2026 – SHOP (Small Business Health Options Program Marketplace Medical QHP and SADPs)